

DNR REQUEST FORM

910 KAR 2:040

(Edition 3/09)

PLEASE PRINT OR TYPE

A. Client Name: _____ Diagnoses: _____
SSN: _____
Date of Birth: _____

ATTACH SUPPORTING DOCUMENTATION FROM THE MEDICAL RECORD

Is Hospice involved in the care of this patient? Yes _____ No _____

B. ONE OF THE FOLLOWING MUST BE CHECKED "YES" FOR DNR STATUS TO BE CONSIDERED:

1. Is the client in a terminal condition? Yes _____ No _____
(A terminal condition is defined as a condition caused by injury, disease or illness which in your estimation is incurable and irreversible and will result in death within a relatively short time, and where the application of life prolonging treatment would serve only to artificially prolong the dying process.)
2. Is the client permanently unconscious? Yes _____ No _____
(Permanently unconscious is defined as a condition characterized by an absence of cerebral cortical functions.)

REGARDLESS OF CODE STATUS, PALLIATIVE CARE WILL BE PROVIDED

(Palliative care is emotional and physical support for the relief of pain and suffering. It includes but is not limited to nutrition, hydration and comfort measures unless specific authority to withhold/withdraw nutrition and hydration has been given.)

Recommended Code Status: _____ Withhold cardiopulmonary resuscitation/DNR

Comments: _____

SIGNATURE of Attending Physician

DATE

PHONE NUMBER

PLEASE PRINT OR TYPE NAME/TITLE

THIS FORM CANNOT BE PROCESSED WITHOUT
LEGIBLE TITLES AFTER THE PRINTED NAME

CONSULTATIVE OPINION

I have reviewed the medical record of and examined the above-named client.

_____ I concur with above request.

_____ I do not concur with the above request

Comments: _____

SIGNATURE of consulting Physician

DATE

PHONE NUMBER

WITHOUT

PLEASE PRINT OR TYPE NAME/TITLE

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C. GUARDIAN: PLEASE PROVIDE A SUMMARY OF CLIENT'S CURRENT STATUS (i.e., ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING (ambulation, transfer, feeding, toileting, bathing), ABILITY TO COMMUNICATE, PAIN STATUS, AND ANY OTHER INFORMATION THAT MAY IMPACT THIS DECISION.

FOR STATISTICAL PURPOSES ONLY: AGE _____ SEX _____ RACE _____ DATE OF APPOINTMENT _____/_____/_____

SIGNATURE: _____